



## Missouri Pharmacy Program- Preferred Drug List



### Ophthalmic Antihistamines

**Effective 04/26/2006**

Revised 05/16/2007

#### Preferred Agents

- Patanol®
- Pataday®

#### Non-Preferred Agents

- Emadine®
- Optivar®
- Zaditor®
- Livostin®
- Elestat®
- Ketotifen Fumerate

<u>Approval Criteria</u>	<u>Denial Criteria</u>
Failure to achieve desired therapeutic outcomes with documented trial period for 1 or more preferred agents.	Lack of adequate trial on required preferred agents.
Documented trial on preferred products	Therapy will be denied if no approval criteria are met.
Documented ADE/ADR to preferred agents.	
Documented compliance on current therapy regimen.	Drug Prior Authorization Hotline: (800) 392-8030.